

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7381 63-030414

FILED JUL 25 1963

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| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF | DOCUMENT |
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| 63 | | SHOULD READ | BY AFFIDAVIT OF |

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|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b 12 days | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hospital | | d. STREET ADDRESS (If outside, give location) 2654 Ann | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First Cecelia Middle Ragogna Last Ragogna | | Month July Day 17 Year 1963 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/26/79 |
| 9. AGE (last birthday) 83 | | IF UNDER 1 YEAR Months 7 Days 21 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Italy | |
| 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | |
| 13a. FATHER'S NAME Pietro Del Bianco | | 13b. MOTHER'S MAIDEN NAME Luiga D'Ambrosio | |
| 14. NAME OF HUSBAND OR WIFE Anthony Ragogna | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Frances Oldani 2654 Ann | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart dis. & Arteriosclerotic renal dis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.0 DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 7/5-7/17 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour 5:15 a.m. p.m. Month, Day, Year 7/5 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION St. Louis, Missouri | |
| 20g. COUNTY | | 20h. STATE | |
| 21. I attended the deceased from 7/5 to 7/17 and last saw her/him alive on 7/17 Death occurred at 5:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Edna Berglund (Name or title) | | 22b. ADDRESS 3203 S Grand | |
| 22c. DATE SIGNED 7/17/63 | | 22d. DATE SIGNED (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7/20/63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Missouri | |
| 24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 Lindell Blvd | | 25. DATE RECD. BY LOCAL REG. JUL 17 1963 | |
| 26. REGISTRAR'S SIGNATURE Head Smith, M.D. | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

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Dr. Berg
3203 S. Grand
1130-400

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Licensed Embalmer No. 4699

P. O. Address 3840 Leland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.